|  |  |
| --- | --- |
| Child’s Full Name      | Today’s Date      |
| **CONTACT INFORMATION** |
| Parent’s/Guardian’s Name      | Telephone      |
| Parent’s/Guardian’s Name      | Telephone      |
| Primary Health Care Provider      | Telephone      |
| Specialist (if applicable)      | Telephone      |
| Specialist (if applicable)       | Telephone      |
| **CHILD’S SPECIAL NEEDS** |
| Diagnosis, if known:       |
| Known symptoms and triggers:       |
| Describe activity, behavioral, or environmental modifications that are needed for the child:       |
| Allergies (other than food allergy):       |
| For food allergies or special dietary needs due to a health condition - must obtain written instructions from child’s health care provider (use page 3 of this form or health care provider’s form) |
| **MEDICATIONS *(Medication Authorization Form must be completed for each medication.)*** |
| List medication to be given at **scheduled times**, and how medication is to be given.       |
| List medication to be given during an **emergency**, and how medication is to be given.      Describe symptoms that would trigger emergency medication.        |
| **EMERGENCY RESPONSE PLAN** |
| List the steps and procedures the early learning or school-age provider should perform during an emergency related to your child’s special need.       |
| **SUGGESTED TRAINING FOR STAFF** |
| List suggested special skills training/education for the early learning or school-age program staff.      |
| **SUPPORTING DOCUMENTATION** |
| Please attach supporting documentation to this Individual Care Plan, including any existing individual educational plan (IEP), individual health plan (IHP), 504 plan, or individualized family service plan (IFSP). WAC 110-300-0300 and 110-301-0300 requires an early learning or school-age provider to have supporting documentation of the child’s special needs provided by the child’s licensed or certified:1. Physician or physician’s assistant
2. Mental health professional
3. Educational professional
4. Social worker with a bachelor’s degree or higher with a specialization in the individual child’s needs; or
5. Registered nurse or advanced registered nurse practitioner.
 |
| **SIGNATURES** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent or Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Early Learning or School-Age Provider Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Health Care Provider Signature*(recommended)* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |
|  |  |
| **This section to be completed by child’s parent or guardian, if applicable:***I hereby give permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to provide*(name of visiting health professional or specialist)*services to my child at this early learning or school-age program.*  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent or Guardian Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |

|  |
| --- |
| **FOOD ALLERGY and/or SPECIAL DIETARY REQUIREMENTS** |
| This page must be completed and signed by the child’s health care provider and parent or guardian. |
|  |
| Child’s Full Name:      | Today’s Date:      |
| Food the child must not consume(list each food separately) | Appropriate substitute food(s) |
|       |       |
|       |       |
|       |       |
|       |       |
| Describe allergic reactions and symptoms associated with this child’s particular allergies.      |
| Describe the treatment plan for the early learning or school-age provider to follow in response to child’s allergic reaction (include names of medication, dosage amount, and directions for how to administer medication).       |
| Other special dietary requirements due to a health condition.      |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Health Care Provider Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent or Guardian Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |